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Developing Gender: The Medical Treatment of Transgender Young People

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Developing Gender: The Medical Treatment of Transgender Young People

Abstract

Situating the contemporary medical treatment of transgender young people - children and adolescents - in the longer history of engagement between transgender activists and the medical community, this article analyzes the World Professional Association for Transgender Health's (WPATH) Standards of Care (SOC) concerning the medical treatment of transgender young people. It traces how the SOC both achieves medical treatment for children and adolescents and reinforces a normative gender system by cleaving to a developmental approach. Without rejecting the value of developmentally-based medical treatment for now, it offers some preliminary thoughts on queer theory's valuation of developmental failure as a potential future alternative to an emergent medico-technological transgender normativity.

Keywords: transgender, child, adolescent, gender dysphoria, gender normativity, hormone suppression therapy, queer

The medical treatment of transgender children is among the newest additions to a history of medical engagements with transgender phenomena that include diagnoses of "transsexualism," "gender identity disorder (GID)," and most recently "gender dysphoria". As historians of transgender demonstrate, transgender medical treatment emerged in the United States from a nexus of medicine, technological change, and political activism in the face of the harsh and

often violent oppression of transgender persons (Hausman, 1995; Meyerowitz, 2009). Given these historical conditions, the establishment of medical treatment was an achievement, but the costs of inclusion in a medical order of things – most obviously pathologization – also plays a part in this history. Together with the already existing history of adult transgender treatment, the long-established distinction between child and adult in Euro-US cultures – including medical culture – points to a linked yet particular story concerning the medical treatment of transgender young people. How does the child enter into this complex history? How has Euro-U.S. transgender medicine incorporated the child, and what are the potential effects of this achievement on transgender young people and on broader understandings of trans/gender?

Concerning Gender

The field of medical provision for transgender young people is fairly well established today, with dedicated clinical teams in the United States (Boston, San Francisco, Washington DC), Canada (Toronto), the Netherlands (Amsterdam), the UK (London) and beyond. Each of these centers follows its own treatment protocol, but medicine is a collaborative practice, in which knowledge is shared through publications, meetings, and organizations. The World Professional Association for Transgender Health (WPATH, formerly the Harry Benjamin International Gender Dysphoria Association, or HBIGDA) is an international multidisciplinary professional association whose stated mission is "to promote evidence based care, education, research, advocacy, public policy and respect in transgender health"

(World Professional Association for Transgender Health (WPATH), n.d.-a). It envisions the organization's work as "bring[ing] together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transgender, transsexual, and gender-variant people in all cultural settings" (World Professional Association for Transgender Health (WPATH), n.d.-a) This organization played a role, alongside other actors, in pushing for depathologizing diagnoses in the DSM-5. WPATH stipulates that its Standards of Care (SOC) are intended to "provide clinical guidance for health professionals" who wish to "assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves" and so to "maximize their overall health, psychological well-being, and self-fulfillment" (World Professional Association for Transgender Health (WPATH), n.d.-b). This approach, based on "the best available science and expert professional consensus," clearly works to support treatment that affirms "gendered selves" (rather than refusing or pathologizing them). As such, it does not articulate debates about treatment, but rather it provides a rationale for it, as well as a comprehensive statement of currently available medical protocols. I use these protocols as the basis for my analysis of the *achievement* of treatment for young people in this field.

The fact that standard terminology surrounding transgender phenomena continues to require explanation indexes the degree to which they are less than fully integrated in dominant Euro-U.S. socio-cultural orders despite a recent marked increase in their mainstream media representation. Furthermore, popular, medical

and psychiatric languages undergo continual changes, often in relation to one another. In the SOC statements quoted above, the term "transgender" functions as a kind of shorthand ("transgender health") for a population that the guidelines otherwise identify more diversely as "transsexual, transgender and gender-variant people." This naming instantiates the current flexible usage of the term "transgender" as both a particular category, which signifies cross-gender identification, and an umbrella category for many different forms of nonconforming gender. I adopt this flexible use of the term in my analysis of the SOC guidelines for the purposes of brevity, but also to emphasize how "transgender" continues to morph both materially and semiotically, in this case particularly with regard to the medical treatment of young people. In addition, I use the term in support of transgender politics' refusal of the pathologization attached to the medical diagnostic term "transsexual," which refers to those whose gender identification conflicts with neonatally assigned gender, and often also to those who seek or have received medical treatment (Meyerowitz, 2009, p. 103). As suggested in the SOC guidelines cited above, the term "transgender" does not assume either a need or desire for medical diagnosis or treatment of any kind. However, in medical discourse the term "transgender" it is consistently associated with medical treatment (Ehrensaft, 2012; Sadjadi, 2013), which includes hormone treatment and relevant surgical procedures (primarily chest or breast construction, and vaginal or penile construction, but also facial and other kinds of plastic surgery) to feminize or masculinize appearance. My analysis traces how transgender becomes a medically treatable category in the case of young people.

This analysis is complicated by the fact that the diagnostic language associated with transgender phenomena has changed fairly rapidly over time, even in the relatively short time since treatment for young people began in the 1970s. In its fifth and latest version, The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association (2013) adopted the language of "gender dysphoria" as compared to "gender identity disorder (GID)" found in the prior DSM-IV Tr edition, which, as the APA puts it, shifted the understanding of transgender phenomena from a notion of "cross-sex identification" to "gender incongruence" (American Psychiatric Association, n.d.); and, as the terms themselves suggest, a shift from pathology to a problem of dys-phoria, or unhappiness, that is not necessarily pathological. Medical literature concerning transgender young people published before the DSM-5 (2013) often refers directly or indirectly to GID, but the SOC guidelines conform to the newer diagnostic language. My analysis considers how the SOC guidelines establish treatment for young persons *through* the concept of "gender dysphoria" as a condition that affects a subset of this group.

Finally, the SOC guidelines also employ a distinction between the (younger) child and the similarly historical-cultural category of the adolescent (Kett, 1993). I use the term "young people" to include both of these categories, and to signal a distinction between the conceptualizations of young people employed in the medical discourse and alternative possibilities that parallels my use of the term "transgender."

Developing Gender

Some kind of gender trouble, some kind of "incongruence" between the sex assigned at birth according to a normative binary gender system and the person's self-identified or self-expressed gender lies at the heart of the medical treatment of transgender persons. Although the expression of this incongruence in adults has been and continues to be the object of some medical scrutiny, in young people it is an even more complex matter. Questions of medical diagnosis and treatment in this case follow from the dual problem of incongruence (shared by adults) and immaturity (unique to young people): what is the nature of the child's gendering, *who* knows (the child, parents or caretakers, professional diagnosticians?) and *when* can this be known for sure in the immature-but-maturing child? Like much of the medical literature concerning this issue (see (Fausto-Sterling, 2012), the SOC answers these questions through its account of medical treatment options for young people that are set aside from those of adults, rather than through an etiological account of (trans)gender itself. And yet accounts of gender necessarily permeate any discussion of transgender concerns.

While such concerns might appear to arise in relation to a previously established account of "normal" gender, historians of transgender phenomena in the United States and Europe have shown that the very concepts of "gender" and "gender identity" arose in relation to the mid-twentieth-century medical encounter with persons who did not identify with the sex assigned to them at birth. The medico-scientific discourse contrasted transgender phenomena with intersex and other conditions of "sex", which it could and did account for in fully biological terms.

In this sense, the concept of gender originated from the need to account for people who claimed a felt sense of their "sex" that was not clearly written on their bodies in the medically legible form of genitals, hormones, and (later) chromosomes (Meyerowitz, 2009).

If we consider medicine in a Foucauldian sense, as a productive form of power (Foucault, 1978), then the task for the medical profession was to subject gender to the medical gaze, making it intelligible and, in the end, treatable. But what form that accounting took, and what treatment it entailed was in no way directly answered by the concept of gender alone (Meyerowitz, 2009, p. 103). In fact, accounts of gender have shifted over time as health professionals (primarily physicians, psychiatrists and psychologists) debated the genesis of transgender self-identifications. An early "bisexual" model held that all humans were born with male and female biological aspects that expressed themselves to different degrees in individual bodies (Meyerowitz, 2009, p. 103). It accounted for cross-gender identification as one permutation within an innate range of potential variation that should be given full expression through medical intervention. The U.S. endocrinologist Harry Benjamin, along with Danish physicians, argued from this model that transsexualism was a physical condition, not a strictly psychological one, and so treatment in the form of hormones and sex reassignment surgery (SRS) were medically appropriate (103). In contrast, psychologists and psychoanalysts employed a model of gender as a strictly psychic phenomenon. This became the basis for a view of transsexualism as a pathological version of gender that required

psychoanalytic or psychotherapeutic intervention aimed at transformation into a normal state (112).

The contemporary treatment of transgender adults – and young people, as we will see – relies on a third model of gender that superseded the second one. By the late 1960s, medico-scientific explanations of gender combined biological and psychological factors rather than separating them completely. Originally proposed by sexologists, this still dualistic but now combined approach won out in the often fierce debates surrounding medical treatment of transsexualism in the U.S. In this case, the very same dualism became the basis for medical treatment that would follow the presenting sex, rather than psychological approaches aimed at "cure" (112). Once committed to the bisexual model, Benjamin and others established a rationale for medical treatment by installing a notion of "*immutable* psychological sex" alongside "biological sex" (112, emphasis mine). This model smuggled biology back in as a defining aspect of the psychological realm, as doctors pointed to an underlying but as yet undiscovered genetic or endocrinal basis for gender. Physicians combined psychological and biological sex to explain what they could only see as cross-gender identification, in a newly supportive way. If the psyche now resolutely fixed by nature could not be changed to fit the soma, physicians argued, then the body would need to be altered to create "harmony" with the mind (113). This version of gender became the "dominant concept in explanations of transsexuality" (117-18) and continues to operate today.

Meyerowitz makes the important point that research on sex, gender and sexuality emerging from transsexuality in the earlier 1960s did not in any way

disturb a normalized binary system of gender or the gender roles that went along with it (118). Foreshadowing a later medical focus on transgender young people as more malleable, less completed bodies than their adult counterparts, psychologists and psychiatrists of the era "developed programs to install masculinity in boys and femininity in girls," as "in the early 1960s the new research had its most immediate practical impact on" children who appeared to adults as "masculine girls and feminine boys" (128). Consistent with a standard normal/pathological bifurcation of nature, these practitioners reinforced a lockstep congruence between gender identification and assigned sex by pathologizing alternative genderings rather than using them as an opportunity to question the existing gendering system.

What is particularly significant about this approach for my own focus on medical treatment of the child is the assumed logic of development that founds this approach: the child as a proto- adult is constituted as a mutable body, available for adult re-configuration, as it traverses a developmental trajectory from immaturity to maturity (Burman, 2007; Castañeda, 2002). Specifically, in this case, the nonnormatively-gender-identified child's psyche is not yet immutable, not yet a full body (Wallace, 1995), and is therefore amenable to transformation in a normalizing (masculine boy, feminine girl) direction. It may well have been due to their status as fully matured, and so less malleable bodies no longer able to benefit from such interventions that this approach had "less immediate impact on the adults who hoped to change their sex" (128).

In any case, the medical treatment of transgender young people that emerged in the 1970s (Zucker, Wood, Singh, & Bradley, 2012) employs a similarly

developmental approach to gender, but following the combined model of gender employed by Benjamin and others, it makes medical (hormonal) treatment possible rather than reinforcing normative gender through psychological therapies. The achievement of young transgender person's medical treatment, in other words, depends on adherence to more broadly established, naturalized distinctions between the child and the adult encapsulated in the term "development."

Anne Fausto-Sterling identifies two general approaches to development, which she names "agnostic" and the "naturalist" (2012: 400), which are proferred by a range of authors included in a special issue of the *Journal of Homosexuality* on transgender childhood and its medical treatment. Included in these groupings are key medical teams (which can include medical doctors, psychologists and/or psychiatrists, and social workers), including those from Toronto (Zucker et al.), the Netherlands (Cohen-Kettenis et al.), San Francisco (Ehrensaft), and Washington, DC (Menvielle). The "agnostic" group includes the Toronto and Netherlands teams. Fausto-Sterling names them "agnostic" because they identify a "multipronged" approach to gender development (biological, psychological and social), but draw no conclusions with regard to medical treament, instead adopting a case-by-case approach (399-400). The "naturalist" group includes Ehrensaft and Menvielle, whose approach to gender relies on a notion of an innately gendered "true self." (Fausto-Sterling sets aside the Boston group (Edwards-Leeper and Spack) as not offering an identifiable model of gender development in their contribution to the special issue. Their approach, which cleaves to the SOC guidelines I analyze below, could fit into either camp.) While clearly different, the two groups share the notion

of biology as a "scaffolding" for the psyche, of a range of gender variance (not just cross-sex identification), and the possible but not necessary role of psychopathology in gender variance (400). Rather surprisingly, these approaches also share a failure to engage with a much more precise scientific account of gender development as a dynamically biological, psychological, and socio-cultural process, according to Fausto-Sterling. Even though they recognize the role of biology and the psyche (as well as the social in the 'naturalists' case), they only do so in a "disconnected" way (401).

These shared characteristics are evident as well in WPATH's Standards of Care. As suggested earlier, the achievement of transgender medicine for young people (and people of any age) cannot be taken as simply given, not only because this is true of all medical treatment, but also in part because, like the treatment of transgender adults, it constitutes treatment of what is otherwise conceived as a perfectly "normal" and "healthy" body. This body must be converted in legitimizable ways into the subject of treatment. I suggest that in the case of young people, this achievement rests on a logic of development that shapes everything from the child, to gender, to medical treatment itself. That is, my analysis emphasizes developmentalism as a central force in this achievement.

In using the term "medical," I refer to *bodily (*medical as opposed to psychological or social) interventions, but these operate in conjunction with psychotherapeutic evaluation and assistance for children and their families, as well as attention to social issues such as what is called "social transition," or circulating in the world as one's desired gender, using choices of dress, activities and so on to

signal that gender identification, separate from any bodily changes. These are important dimensions of overall treatment protocols. I consider physical interventions as a story of their own within this larger treatment picture, while addressing ways in which psychological and social dimensions of treatment play a role in its establishment. In conversation with contemporary transgender theory, I go on to suggest that the medical treatment of transgender children's reliance on a developmental model of gender further sustains a too-limited approach to gendered embodiment that ultimately reinforces a normative system of *trans*gender.

Developing Trans/Gender

WPATH's well-established Standards of Care (SOC, 2012), now in their seventh version, aim to "provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment" (1). Again, the SOC clearly take transgender person's self-identified needs and desires as a point of departure, and in so doing allow for but do not assume the need for medical treatment including hormones and SRS. Leaving aside the assumed self-evidence of self-identity that underpins the above SOC statement, it is important to note that when it comes to children the guidelines are more equivocal in their advocacy. The SOC section on "Assessment and Treatment for Children and Adolescents With Gender Dysphoria" immediately announces the developmental stage of adolescence as a key consideration in gender dysphoria. The term

"adolescence" is a late-nineteenth to early-twentieth century invention of U.S. psychologist Stanley G. Hall and his colleagues, which newly established the teen years not as the first years of full adult status, as they had been previously, but as a "moratorium" from adult responsibilities to come (Kett 2003). Adolescence has come to be associated more recently with a "biopsychosocial" model of development, in which adolescence constitutes a specific stage in a developmental trajectory that goes from infancy to adulthood, marked by linked biological (bodily), psychological, and social changes and challenges (Christie, 2005).

Signaling adolescence as a further refinement in the distinction between child and adult, the SOC identifies "a number of differences" between "children, adolescents, and adults" in "phenomenology, developmental course, and treatment approaches for gender dysphoria." These differences are all developmental, the SOC go on to advise: "In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and there is a greater fluidity and variability in outcomes" (10-11). Due to this important developmental distinction between children and adolescents versus adults, the SOC provides "specific guidelines" for "the assessment and treatment of gender dysphoric treatment of children and adolescents" (11). The resulting guidelines trace the child-body's developmental transformation from an initially greater "fluidity and variablity" to a later less mutable but not yet fully adult state. In a section titled "Differences Between Children and Adolescents with Gender Dysphoria," the SOC guidelines identify as critical the relatively small "proportion [of children] for whom dysphoria persists into adulthood" (11).

As the guidelines' reference to persistence suggests, this approach establishes a particular temporality and pacing for the child-body's gendered development. The guidelines go on to note not only that "[g]ender dysphoria does not inevitably continue into adulthood," but that persistance is in fact relatively rare, as various studies show that it occurs in only 6–23% of boys and 12-27% of girls (11). Highly fluid and even evanescent in early childhood, "gender dysphoria will disappear before, or early in, puberty" (11). In this formulation, the term "puberty" names bodily transformations very much bound up with what Benjamin would call "biological sex" that become a developmental boundary for gender fluidity. In other words, according to this model, gender fluidity develops into greater gender stability at a subsequent and necessarily higher stage in the teleologic economy of development.

Of course, development can take a pathological turn, in which case a subsequent step does not automatically entail progress. Consequently, the medical model of gender development arguably cannot provide the grounds for treatment without both addressing the developmental specificity of pre-adults – the "nature" of child-bodies that must be addressed (even if only to be put aside) in all medical decision-making concerning young people --; nor without making a case against pathological forms of development that would lead treatment in the direction of psychological cure. As we have seen, the spectre of *psycho*-pathology looms larger than bio-pathology in the history of transgender medicine, and no less so with regard to children. In fact, most accounts of transgender youth in the medical literature, including the SOC's, seek to distinguish gender dysphoria in pre-adults

from psychopathological causes of nonconforming gender identification. Kenneth Zucker's Toronto clinical group (2012) tends to emphasize the existence of alternative (and implicitly pathological) reasons for cross-gender identification in children (versus adolescents), while affirming some existence of non-pathological gender dysphoria in this population. In contrast, the SOC emphasizes the predominant absence of such pathology, and the danger of pathologizing what is actually a normal variance. It warns that "[i]nexperienced clinicians may mistake indications of gender dysphoria for delusions." To avoid such confusion, it advises that "phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe phsychiatric illness such as psychotic disorders" (13). Prepubertal gender dysphoria is thus rendered an almost entirely normal developmental variation, in the sense that it not only requires no treatment but exists in contradistinction to other potentially more pathological causes of what is otherwise legitimately gender dysphoria, whether the approach sees the latter as more or less rare.

Returning to puberty as a key moment in transgender development, it marks not only a greater (but still incomplete) stabilization of gender identification, but also indicates further gender-related developments in transgender youth. That is, the SOC observes that gender dysphoria may *increase* at puberty. For the smaller proportion of children in whom gender dysphoria "persists" into puberty, not only will "these feelings [ ] intensify," but so will "bodily aversion [ ] develop or increase

as they become adolescents and their secondary sex characteristics develop" (12). Whereas the earlier mutability of gender development obviated against any medical intervention, this stage of development becomes a moment of gender consolidation and even intensification. Furthermore, the developmental trajectory of gender can, according to this account, shift disjunctively into gender dysphoria with no prior indication in pre-pubertal childhood. Putting the two modes of gender development together, it is clear again that puberty constitutes a domain of more consolidated gender identification whose threshold young people must cross into from either a prior, more mutable nonconforming-gendered state or from a prior more gender-normative state.

And so it is at this point in the developmental trajectory that transgender medicine can legitimately gain access to the transgender body. Citing two studies on the matter, the SOC establishes a lesser but still existant gender mutability in terms of "adolescent development," or the nature of adolescence as itself an idiosyncratic developmental phase, in which "identity beliefs…may become firmly held and strongly expressed, giving a false impression of irreversibility"(12). The guidelines caution that "an adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria." Rather than simply guarding against improper treatment, this statement is also directed at ensuring the possibility of further treatment, or at least the persistence of gender dysphoria in this developmental stage.

But what treatment can this entail, if the pubertal young person, who is by

definition undergoing a developmental process of maturation, is more developed than its younger counterpart, but not yet fully developed as an adult, and might claim a merely temporarily strategic gender identification at this very moment? Introducing a further series of treatment-based stages, the SOC establish a transgender-specific developmental treatment trajectory that enables medical treatment by conforming to the broader trajectory of gender development. The first treatment stage involves puberty suppression. This refers to the use of GnRH analogues, which when injected into the body stop communication from the hormones to the gonads that would otherwise begin to take place, thereby temporarily interrupting sexual development. These drugs are often called "puberty blockers" because of this interruptive capacity (Roberts 2014: 179).

A central feature of GnRH analogues is their reported reversibility. Rather than moving the body into further development associated with gender, these drugs put these changes on hold. The drugs' effects are "reversible" in the sense that when treatment ceases, pubertal development can purportedly resume its original course. Reversibility thus becomes developmentally necessary, due to the ongoing mutability of gender in adolescence, and the fact that the installation of this reversibility can ultimately point towards *either* gender in future stages. In fact, the SOC structure the medical treatment of adolescents in three stages based on their decreasing reversibility, conforming the developing body's decreasing mutability. GNrH and comparable treatments (including the use of birth control pills to suspend menses and alternative hormone-inhibiting drugs like progestin) are "fully reversible," and as suggested above, this is central to the treatment's legitimacy.

According to the SOC, two specific outcomes "justify" the use of GnRH and comparable treatments (19). The first is that "their use gives adolescents more time to explore their gender nonconformity and other developmental issues" and the second is that "their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment" (19). In other words, young people in early adolescence are still developmentally in process with regard to gender, such that treatment should assist them in their still only potential cross-gender identification in the sense of preserving future possibilities for gender transformation, but it should not fix their bodily sex in any way. To suspend gender development keeps gender options open without actually pointing the physical body in any particular direction. The drug treatments' "reversibility" underpins and ensures this flexibility.

At the same time, "suppression" clearly refers not just to the act of merely suspending a pubertal developmental process, but also to intervening in developmental processes that would otherwise continue, producing a potentially undesirably gendered body. So too, the desired developmental outcome for "persistently" cross-gender identified young people at this stage will quite speficially not be satisfied by ceasing the suspension and allow development to continue on its prior trajectory. Instead, gender development must be assisted by medicine in the form of cross-sex hormone treatment. The SOC describes this second medical intervention as "partially reversible," identifying it as a next step toward cross-gender fixity through treatment. The treatments involve "hormone therapy to masculinize or feminize the body," and they are only partially reversible

in that "[s]ome hormone changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone)" (18). This treatment still preserves some developmental mutability, but now in a more limited sense.

At this point, the SOC guidelines send the adolescent body on its way to cross-gender embodiment through physical intervention, shifting the body's (presumed) normative existing developmental trajectory in the direction of the non-normative self-identified gender. As I have noted previously, the medical developmental model of gender is a biopsychosocial one. Treatment proposed by the SOC for young people consequently address all three of these linked dimensions. Key steps in medical (physical) treatment are accompanied by psychological assesment and assistance for both young people and their families, alongside considerations about "social transition" – enacting transgender in social domains like school and extended family, since "[b]efore any physical interventions are considered for adolescents, extensive exploration of psychological, family and social issues should be undertaken" (SOC 18). The SOC also make specific reference to the ways in which individual children might follow idiosyncratic or particular developmental trajectories within and across these three dimensions, and advise practitioners to remain alive to these variations (18). Still, they are variations on a fairly standardized account of gender development and treatment, as the formulation of reversible-to-irreversible treatment staging suggests.

The SOC's final stage in physical transition is surgical intervention. The SOC

lays out particularly careful criteria for this "irreversible" treatment, stipulating that it should only be carried out if "patients reach the legal age of majority to give consent for medical procedures in a given country" and "patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity." (21). That medicine conforms to legal definitions of (adult or mature) "consent" only at this particular point raises a much larger set of issues concerning young people's – as compared to their parents' – consent to medical treatment (Drescher & Byne, 2012b). Rather than turning to the legal dimensions of a developmental approach, I continue focusing on the developmental logic underpinning treatment protocols. The second requirement, that young people experience living in the gender role that corresponds to their gender identity has long been in place for adults. While it may well recognize the ways in which changing one's externally-perceived gender is a highly social matter – to say the least, given the high levels of violence and other forms of oppression that transgender people routinely experience – this requirement also suggests that transgender identification is not considered sufficiently natural or innate to merit treatment on the basis of a person's self-identification, regardless of consent. Self-identified gender must be achieved and consolidated through social experience. In contrast to the adult scenario, however, the adolescent body's status as still-developing bodies, following the biopsychosocial model of gender development, further underpins this requirement.

Interestingly, the SOC guidelines do allow for chest surgery in FtM (female-to-male) young people earlier than the age of legal consent, again "preferably after

ample time of living in the desired gender role" and "after one year of testosterone treatment." (21). Following a similar developmentally-inflected intent to "give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role before undergoing irreversible surgery" by imposing these social and medical requirements (as testosterone presumably begins a bodily transition in which such a masculine role can be more easily experienced), the guidelines offer no reasoning for selecting only FtM adolescents for this treatment. There is arguably nothing self-evident about chest surgery from the point of view of a medical discourse seeking to carefully establish the legitimacy of treatment (including limits on treatment), nor is there anything self-evident about the difference between chest surgery for FtM persons as compared to MtF persons that would legitimize its earlier use. This twist in the guidelines points to the flexibility of a developmental logic as the underpinning of medical treatment, but it remains consistent with that logic in the sense that in this case treatment becomes not simply imaginable but indeed almost developmentally necessary as a form of medical care for carefully selected individuals.

A detailed analysis of the force of development in establishing the contours of medical treatment for transgender young people may account for its successful achievement, but it does not necessarily constitute either a further legitimation or critique concerning the effects of this treatment on transgender young people or on gender more broadly. The Standards of Care identify their own position on such political or ethical dimensions of treatment somewhat indirectly. Observing that "neither puberty suppression nor allowing puberty to occur is a neutral act," (20)

the guidelines go on to advise that:

> Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence …withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents. (20)

The rhetoric of this statement clearly works in the direction of further legitimizing and even encouraging medical treatment for young people, in the name of avoiding social harm and associated psychological damage. It further reinforces the SOC guidelines' work to achieve medical treatment for transgender young people through a carefully ordered mix of developmentally-based ("timely") caution *and* authorization.

The body's development, and so also the SOC's (and transgender medicine's) reliance on it as a basis for the treatment of young people might seem so unquestionable as to obviate the above analysis. Some might further suggest that the real problem with this treatment is its intervention in normal developmental processes that should not be tampered with in young people, particularly before the age of consent. However, this is not the direction that my criticism takes. As I turn a critical eye to the medical treatment of transgender children, I am aware of the struggles of transgender children, adults, and their families, of the injustices they

face, and of the efforts of medical professionals to do no harm and to provide care today, not in some ideal imagined future. Nevertheless, with other feminist/transgender theorists, I seek to question the ways in which transgender medicine reinforces normative gender even as it seeks to assist children in negotiating its forces in livable ways. My argument is not that transgender medical treatment of young people should not exist, nor that it is centrally responsible for the gender systems in which it operates, nor even that those who work in transgender medicine are immune to questioning normative gendering. My analysis seeks instead to speak to the *way* the medical treatment of gender dysphoria in young people constitutes gender more rather than less normatively, and to point to ways of enabling a more expansive range of possibilities for liveable embodiment with respect to gender and its very particular Euro-US histories.

Re-treating Gender

Rooted in a European colonial/imperial discourse that incorporated everything from scientists' children to race to whole peoples and nations in a linear hierarchy of progress, development has been the subject of scholarly critique as a form of power that imposes a necessarily unequal hierarchy of value on that which it purportedly only organizes and explains. Numerous authors have addressed the ways in which development – a concept that spans domains from biology to international aid – naturalizes and/or normalizes such unequal orderings and the ideas and actions that follow from them (Burman, 2007; Castañeda, 2002). Erica Burman (2013) identifies the "desire for development" or "the developmental

imperative," as a force whose "teleology of progress and accumulation" on a national and global level she finds "*writ small*, recapitulated in the micro-sexed/gendered/body political narrative of individual development" (see also Castañeda 2001). In transgender medicine, this developmental force arguably enables problematically normative and naturalized effects even as it makes possible certain kinds of treatment for transgender young people.

In an important critique of hormone supression therapy for young people, Sahar Sadjadi (Sadjadi, 2013) focuses on dramatic narratives employed in promoting the treatment. Sadjadi analyzes how narratives of puberty as a medical "emergency," figure puberty as a nefarious impending event that may give rise to violence, suicide, self-harm, and mental illness (257). She argues that "locating the cause of that suffering and violence within the child," this narrative gives puberty suppression force as a necessary means of "preventing the body from developing unwanted secondary sex characteristics" that will "save" children from a "frightening and abject future"(259). As Sadjadi puts it, such a narrative "may not be conducive to the well-being of gender non-conforming children" (259). She goes on to observe that the health effects of puberty suppression techniques, "are relatively unexplored" and so may pose as yet undiscovered risks (259; see also (Roberts, 2014). Furthermore, puberty suppression is the gateway to cross-sex hormone treatments, which are known to cause infertility (hence their only partial reversibility).

The SOC include this eventuality without comment, simply noting that with

regard to the effects of treatment on reproductive capacity, "[a]t this time there is no technique for preserving function from the gonads" of a "special group of individuals," namely "prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross-gender hormones" (51). (The SOC guidelines seem to claim that even puberty suppression ("blockers") causes infertility, although this is not mentioned elsewhere in the literature, or in Sadjadi's analysis. I have not found an explanation for this discrepancy, and leave it as a question for further analysis that is beyond the scope of this paper.) This surprising lack of commentary on the loss of reproductive function, which is otherwise highly prized in Euro-US cultures, provides further support for Sadjadi's concern about the absence of any substantive bioethical discussion on this matter in the relevant literature. "For any other group of children," she writes, "such an intervention would be discussed extensively with ethics review boards" (5). The absence of such review would seem to indicate that an identifiably normatively *embodied* gender trumps reproduction as a fundamental social requirement of human being – a point to which I will return.

The narrative of medical emergency that Sadjadi identifies itself relies on development as the force that produces this emergency, the engine of impending pubertal changes that will feminize or masculinize the body in an undesired way. Indeed, Sadjadi's primary criticism concerns the effects of such narratives on parents' and broader cultural understandings of transgender phenomena. "Most importantly," she advises, "we should pause on the paradox of helping and saving the 'transgender child' from the development of bodily features incongruent with

their gender identities, through a narrative of suffering and abjection of transgender life." She asks, "[i]s this account trans-friendly, as currently perceived, or does it inadvertently promise the *prevention of visible transgender adults?*"(5, emphasis mine.) These effects clearly arise out of a developmentally-based distinction between young and adult transgender persons – that is, those still undergoing development and those who have completed that trajectory. Sadjadi's reference to the "visibility" of adult transgender embodiment (voice, stature, etc.) speaks to the ways in which adult bodies that undergo transgender medical treatment bear the marks of that treatment in ways that make it almost impossible to fully "pass" as the desired male or female gender regardless of a person's desire to do so (or not). As Sadjadi notes, the promise of treatment earlier in life – that is, in a state of incomplete development – is that it can fully avoid such problematic marking, as the SOC clearly state in their reference to the treatment of young people as a way of avoiding "an appearance that could provoke abuse and stigmatization" (20, cited above).

It is exactly at this juncture, where the transgender young person meets the adult, who becomes a kind of lesser version of transgender – because less completely trans-gendered in a bodily sense – that trouble arises. It is at this juncture, too, where the guidelines' careful mixture of caution and authorization enacts a slippage between the establishment of gender dysphoria as internal to the young person in relation to non-normative gendered self-identification and the effects of external (social) abuse and stigmatization. Again, this angle on the SOC might become a way of arguing against all bodily alteration of transgender young

people. But this would create a false distinction between transgender medical technologies and all of the other technologies with which bodies in contemporary worlds are materially entangled (consider vaccines, to name one technology particularly relevant to young people and newly subject to debate). In "The King's Member, Queen's Body: Transsexual Surgery Self-Demand Amputation and the Somatechnics of Sovereign Power" (2009), feminist/transgender theorists Susan Stryker and Nikki Sullivan emphasize the historical situatedness of contemporary self-identifications associated with medically-involved body alteration (including hormone therapy and SRS, and self-demand amputation) and their relation to a Foucauldian version of power as a productive rather than simply repressive force. Recognizing that transgender has (just barely) become a "normalized transgression" when it had once been a nearly unintelligible and then pathologized condition, Stryker and Sullivan understand this achievement as a compromise between gendered desires and the workings of power, rather than as a fully liberatory success. The "queen's body" – the female transgender body:

> [s]ecures its passage to transsexual womanhood, to life as she wants to live it, through a perilous exchange that frees her from a double bind. In seeking the embodiment that sustains her life, she must appeal to the sovereign powers vested in the medico-juridical complex, whilst simultaneously countering the threat of mayhem upon the king's member. (59)

The king's member here signifies not just the male sexual organ but also the patriarchal order of things. The transgender person who desires medical treatment

must rely on being interpellated by this order of things, specifically medicine as it intersects with the law (which can mandate whether and what treatment must be allowed or refused), to achieve desired bodily transformations. At the same time, by literally and figuratively undoing maleness in and through the body, the MtF transsexual, in Stryker and Sullivan's account, poses a "radical threat" to those very systems of power. The woman mitigates against that threat by conforming in her very flesh to the standards of (female) gender, and in so doing also becoming a legitimated and productive member of society, rather than existing on its margins:

> This transgender body, though dis-membered in one register, becomes re-membered and re-articulated in others…It becomes a body that reproduces, through its atypical technologisation, the visual norms of gendered embodiment that form part of the routine functioning of the social body; it becomes a body more suited for taxable work, for purposes more readily harnessed to purposes of the state. (59)

While there are important differences bewteen MtF and FtM phenomena that the text's references to the "King's member" and the "Queen's body" identify, the salient point for my purposes is that the achievement of medical treatment is not only a way of becoming a subject *of* power, but also necessarily subjected *to* power (see also Butler, 1997); normalization – even the more tentative "normalized transgression" of transgender – is a heavy price to pay for incorporation, in every sense of the word. Moreover, since adult transgender treatments follow a similar trajectory as young people's (excluding the option of hormone suppression therapy)

– from hormone treatments, to living as the desired gender, to undergoing surgical procedures (see SOC) – it could be argued that they are required to regress developmentally, returning to a state of immaturity so that they may *become* the gendered subjects they desire to be, while undergoing a re-subjectification to power through this very re-development.

In any case, Stryker and Sullivan argue that any body politics that *follows* transgender success in a historical sense does not have the option of effective transgression in the same way. Foucault's freedom is an ever-receding horizon in that political success always redraws the boundaries of normativity to include prior spaces of transgression. Whereas gaining access to medical treatment was an important political goal in its time, the success of the movement that made transgender a "normalized transgression" in turn calls for newly transgressive political aims. The authors conclude that whatever form such a body politics or "appeal to justice" takes, it "should *not* take the form of a *right* to morphological self-determination" (61; original emphasis), because this approach "expresses a historically and culturally specific legitimising [Eurocentric] fiction" of self-identity, in which one's body and identity are one's property and only in this (economic) sense can one "freely" determine them as one wishes and take "responsibility" for those decisions. Most importantly, "that fiction is not without its material costs, for it imagines an autonomous, trascendent, universalisable body that, in its infinite malleability, is ultimately unattainable" (61). I would add, furthermore, that however fictional, this self-possessive body is a privileged one, extended differentially to middle- and upper-class able-bodied white subjects (Lipsitz, 2006).

How does this fictional body-as-property figure in relation to young transgender people? Hidden in the medical discourse concerning their treatment is precisely a version of bodily self-possession, mitigated but also promoted by development. The young person's gendered desire, or transgendered self-identification, plays a significant role in the SOC's carefully circumscribed criteria for persistent gender dysphoria. This desire is both destablized by development (the young person cannot yet be sure of his or her gendered identity, and it may morph into something else or disappear), and also *requires* developmentally-inflected treatment (once it is sufficiently stabilized, and before puberty registers a conflicting gender in the developing body). Treatment becomes a developmental *need* for (if not also a *right* to, increasingly, alongside development in the direction of becoming a full subject) bodily transformation. In the U.S. specifically, "price" does not refer only to the economic basis of personhood as described by Stryker and Sullivan, but also to the actual cost of treatment under the current health care system. Hormone suppression therapy is particular costly, and in the historical absence of universal health care coverage, only young people of relative wealth can afford such treatment. Given U.S. histories of inequality, this means that this group – including an as yet inexplicably disproportionate number of international adoptees – come from predominantly white and upper-middle class or owning class families.

The price of this literal and figurative incorporation as a quasi-subject (more subject as parental consent gives way to the young person's consent) of medical treament, is precisely subjection *to* a particular normativity, one that conforms to existing *trans*gender normativities that are fully evident in the SOC guidelines,

despite explicit references to gender variance , variant treatment, and gender dysphoria as non-isomorphic with nonconforming gender self-identifications. The developmental treatment trajectory from reversible hormone suppression therapy to cross-sex hormone treatments (and in the case of FtMs as discussed above, surgery) figures a normatively binary production of gendered embodiment. First, the instability of children's nonnormative gender identification is always treated in terms of whether it persists or not, either returning the child to an unproblematic gender or pushing forward to one that may require treatment. Hormone suppression therapy functions in a similar way, preserving the possibility of such a return, while at the same time ensuring an undetectable gendered re-embodiment at a later stage. Cross-sex hormone treatment as described in the SOC begins the process of installing gender in the body along either male or female lines to ultimately achieve a more properly functional gendered body than can even be attained in an adult. The logical outcome of this achievement, which the SOC also explicitly identifies (see above discussion), is that early diagnosis and treatment could eventually erase all traces of transgenderism in the adult population, creating a marginalised class of otherwise gendered (genderqueer, non-operative transgender, non-gendered etc.) children as well as adults, and perhaps even pathologizing those who might refuse medical treatment.

Far-fetched? Perhaps. But the ultimate unattainability to which Stryker and Sullivan refer (see above) is precisely the "proper" body, which is to say the body *as* property, as a possession of mine to determine as I wish. This body is unattainable because all bodies are imbricated in the machinations of power that make them

intelligible in the first place, and gender is one among the categories that enables that intelligibility in particular ways. Furthermore, embodiment is always partial in some way, "torn, rent, incomplete" because it *is* perpetually technologically composed in one way rather than another, given "a context in which bodies are always already enmeshed/enfleshed in a sociotechnical apparatus" (50). To recognize this perpetual enmeshment is to consider issues of social integration that more effectively take into account the body's *lack* of any originary integrity, which would otherwise subvert claims to technological alteration. Stryker and Sullivan write that: "the integrity of the body – that is, the ability of the body *to be integrated* – is… paradoxically, dependent on [this] enfleshment as already torn, rent, incomplete and unwhole" (61). In other words, for a body to be integrable it must have a ragged edge, an opening to some kind of connection rather than being entirely self-contained. Importantly, Stryker and Sullivan do not advocate "an account of the good – or better – life to be attained through proper application of [body-altering] technologies" (61), because that would only reinforce false notions of bodily integrity. My analysis of the SOC suggests that the guidelines propose just this kind of approach: the guidelines' careful negotiation of development make proper the application of body-altering technologies to transgender young people's lives in the name of offering them better lives. In place of such an approach, Stryker and Sullivan call for, "a critical interrogation, a queering of the contextually specific ways in which … legitimising fictions … simultaneously enable certain modes or forms of bodily being, whilst denigrating or foreclosing others" (61).

Failing Development

What kinds of embodied being does the legitimising fiction of development grounding the medical treatment of transgender young people foreclose? I offer two paradoxical responses. The first is that the SOC guidelines on young people fail to authorize any form of technological alteration of young bodies that is not normatively – in this case developmentally – transgressive, one that does not conform to either the masculine or the feminine, in binary terms, as these emerge in a developmental trajectory. Although the SOC explicitly identify the "diversity in…gender identities, roles and expressions" (9) including non-binary ones, their developmentally-inflected approach to young people and medical treatment, as I have tried to show, pushes in a much more restrictively normative direction. If the SOC seek to achieve treatment for transgender young people, should they not also seek to achieve treatment for those who do not so readily conform to a binary system of gender? Why should such desires be separated out from more obviously binary ones? This objection is clearly limited in that it suggests merely expanding the category of bodies that can be inserted into the developmental trajectory of medical treatment, though it also seeks to open up forms of non-normatively gendered bodily transgression that are less normative at this historical moment. A more thoroughgoing response requires disrupting development itself. If development legitimises particular forms of technological embodiment for young people achieved through medical treatment, then what they also foreclose, or at least ignore, in achieving technological transformations, is a different order of things altogether.

The risk of disrupting the developmental scaffolding for the achievement of

medical treatment for transgender young people is that this can entirely dismantle the rationale for treatment. As I have noted above, this is not my aim. However, I do think it is important to imagine an alternative future, a different order of things, in which gender might become something else altogether especially given the increasing normativity of the bodily transgressions at issue. Furthermore, in a thoroughly technologized world, and as treatment moves from adults to young people with their apparent capacity for more invisible transformation, the SOC guidelines, wittingly or not, are themselves an indication of how changing one's body to fit one's gendered identification is increasingly becoming an enactment of a normalized *developmental* transgression. What the guidelines do not address, or only barely so, is that the *bodily* dys-phoria of gender exceeds attempts to resolve it through medical treatment, precisely because such treatment makes the false promise of full bodily self-possession, and a kind of completeness of self that is unattainable *even* through developmental interventions and *because* development is arguably a legitimising but ultimately disappointing fiction.

This may seem a mere theoretical slight-of-hand, given that so many studies report that transgender young people (and adults for that matter) are relieved of their dysphoria after treatment (see (Drescher & Byne, 2012a). But the capacity to function effectively and even happily in a social system is not the measure of freedom or justice, though it is certainly an understadable goal for young people, especially considering the realities of abuse and stigmatization. In the end, greater freedom and justice may emerge from what J. Halberstam has articulated as the "queer art of failure," which includes the *failure* to develop, to become a proper –

and properly (trans)gendered adult (Halberstam, 2011; Owen, 2014, p. s; Stockton, 2009). The task of disrupting development, as Halberstam puts it, requires undermining the "temporal order" that "assigns dreams of transformation to pre-adulthood and that claims the accommodation of dysfunctional presents as part and parcel of normative adulthood" (31). This description of a "temporal order" neatly recapitulates the developmentalism of transgender medical treatment that constitutes young persons as uniquely transformable bodies in pre-adulthood, who may achieve legitimately gendered adulthood by accommodating to developmentally normalized medical treatment. To disrupt this order is to take the possibility of transformation out of any specific position on a linear developmental trajectory (thereby undoing the trajectory itself, or at least its rationale) and to refuse accommodation to a dysfunctionally gendered present. This task is not one that we adults (of any gender identification) can assign to transgender young people, nor is it one whose path can be laid out ahead of time. But certainly there is already plenty of evidence that few if any of us actually follow a normal developmental trajectory. We stop and turn and change and stall. When Halberstam identifies "strange and and inconsistent" alternatives to developmental success, she imagines "building new worlds by accessing new forms of sociality" (32). Ultimately, leaving behind notions of developmentally gendered success can open up new forms of being and being with others that offer greater freedom for more beings no matter their techno-biological bodily form.

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Re-Treating Gender: The Medical Treatment of Transgender Young People

Highlights

- Explores the medical treatment of transgender young people as an achievement
- Situates treatment in history of transgender activism, treatment, and normalization
- Analyzes biological development as obstacle and enabling force in standards of care
- Challenges developmental reinforcement of normative gender in treatment standards